



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SOUTH TEXAS HEALTH SYSTEM
3255 WEST PIONEER PARKWAY
ARLINGTON TX 76013

MFDR Tracking Number

M4-09-4497-01

Respondent Name

EMPLOYERS ASSURANCE CO

Carrier's Austin Representative Box

Box Number 34

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have found in this audit you have not paid what we determine as a 'fair and reasonable' amount for this outpatient surgery. Understanding that DWC of TDI is wanting to move to a hospital reimbursement of a %-over-Medicare, we have used that methodology in our calculation of fair and reasonable. Medicare would have reimbursed the provider at the based APC rate of \$2307.40. Allowing this at 140% would yield a fair and reasonable allowance of \$3230.36. Per Texas Fee Schedule out patient surgeries are to be paid according to the Medicare OPPTS system. Based on your payment of \$0.00 a supplement payment is still due." "**Also please note that implant charges are still not paid at this time." "We respectfully ask that you reprocess this line item charge at the correct Medicare allowable at 200% minus your previous payment."

Amount in Dispute: \$8347.15

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the Carrier's position that:

- The requester Healthcare Recovery Alliance is not a party to this dispute.
- There was no fee schedule reimbursement for the charge in dispute.
- The requester requested dispute resolution for APC codes 22 and 63 only per the dispute position statement.
- There are NO charges associated with code 27524, therefore, no reimbursement is due for code 27524.
- If code 27524 had been billed, no reimbursement would have been due for code 20680 per National Correct Coding Initiative.
- The carrier reimbursed the requester \$1,558.70 for implants and No additional is due.
- The requestor failed to produce any credible evidence that its billing for the disputed procedures is fair and reasonable.
- The requestor failed to prove that the amount billed is usual and customary compliance with fees for the service in dispute is fair and reasonable are consistent with Section 413.011(a-d).
- The Carrier's payment is consistent with fair and reasonable criteria established in Section 413.011(a-d) of the Texas Labor Code."

Response Submitted by: AmComp Assurance, Dawn Cheshier, P.O. Box 164347, Austin, TX 78716

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
December 18, 2007	Outpatient Surgery	\$8347.15	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. This request for medical fee dispute resolution was received by the Division on December 18, 2008.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 97-Payment is included in the allowance for another service/procedure. The reimbursement for this line item has been included in the payment. Recommendation(s) for all covered services which are reported on another line or lines.
 - W1-Workers Compensation state fee schedule adjustment. Fee guideline MAR reduction.
 - W10-No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology. Reduced to fair and reasonable.
 - 50-Requested documentation not submitted with the medical bill. Not documented. In order to review this charge we need a copy of the invoice detailing cost to provider.
 - W4-No addl reimb allowed after review of appeal/recon. We reviewed your reconsideration and determined that the original reason for denial/reduction was correct. Please refer to the initial explanation of benefits.
 - W4-No additional reimbursement allowed after review of appeal/reconsideration.
 - W3-Additional payment made on appeal/reconsideration.

Findings

1. 28 Texas Administrative Code §133.307(c)(2)(G), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
 - The requestor's position statement asserts that "Understanding that DWC of TDI is wanting to move to a hospital reimbursement of a %-over-Medicare, we have used that methodology in our calculation of fair and reasonable. Medicare would have reimbursed the provider at the based APC rate of \$2307.40. Allowing this at 140% would yield a fair and reasonable allowance of \$3230.36. Per Texas Fee Schedule out patient surgeries are to be paid according to the Medicare OPPS system. Based on your payment of \$0.00 a supplement payment is still due." "Also please note that implant charges are still not paid at this time." "We respectfully ask that you reprocess this line item charge at the correct Medicare allowable at 200% minus your previous payment."
 - The requestor did not list which APC was used in their position statement to determine the rate.

- The requestor did not discuss or explain how it determined that 140% and 200% of the Medicare rate would yield a fair and reasonable reimbursement.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

10/6/2011

Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.